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The Division of Primary Care in West Virginia is part of the Department of Health and Human Resources, Bureau for Public Health. The Division is the State's agency for support of community based primary care organizations. Basically, that means organizations that are independent, non-profit, and have governing boards from the community with user representation. These include free clinics, or health rights, Community Health Centers, FQHC Look-Alikes, community based specialty clinics, school based health centers, and black lung clinics.

The State of West Virginia allocates about twelve million dollars for support of these organizations. Most of that money is in direct aid for the uncompensated quality health care provided by these organizations. The following figures are from calendar year 2003. In all, the centers have over 300,000 users. Of those, about 50,000 are users of the free clinics. Those are uninsured people with limited resources who receive free primary care and assistance in utilizing the indigent drug programs available as well as donated medications. The free clinics are, for the most part, located in the population centers of the state, but see many rural residents. Of the community health centers, specialty clinics and other FQHCs, 28 percent are uninsured and about 28 percent are insured. About a third of the users are in the Medicaid program. Only 12 percent are covered by Medicare. Users aged 50 and older make up only about a quarter of the total.

Although free clinics provide free medications to Medicare users because they have no drug coverage, they may not provide primary care services to those who qualify for Medicare medical coverage. It appears that many of the pharmaceutical company indigent drug programs will not be available to Medicare eligible after January 1, 2006. This is because of the new Medicare drug program. Not all of those Medicare eligible may be able to afford even the small premiums and co-pays required under the program. Thus, the new federal program will result in a loss of health care access, at least in relation to medications, for a number of elderly West Virginians.

Community-based primary care organizations are a major part of the state's health safety net. They are supported so that all state residents, regardless of ability to pay, can have access to high quality health care. Although there are many aged West Virginians who have difficulty paying for health care, their needs may not be best met in community primary care settings. Those centers may be better suited to providing health care to younger adults.

Most of the community based primary care organizations in West Virginia are FQHCs with enhanced reimbursement from Medicaid and Medicare. Their cost based rate is affected by the productivity of their providers. To increase productivity,

there is a need to spend less time with more patients. The complexity of the health status of older West Virginians requires longer provider visits. That complexity also leads more quickly to the need for specialist care that takes the patient out of the scope of primary care services. There is also a need for more training of family practice providers in geriatric medicine.

West Virginians are working on these issues. A project is being designed that will create a partnership between a rural community health center near Charleston, a large hospital there and West Virginia University's School of Medicine. There will be an FQHC clinic specializing in geriatric primary care. Medical and nursing students will be better trained through this new Geriatric Center of Excellence and new practices will be developed for better care for the elderly in a community based primary care setting. Other community based primary care organizations will be included in training and partnership programs to see if the model developed in Charleston can be taken to more rural sites.

The federal government can better assist the safety net health providers of West Virginia by adjusting productivity goals for FQHCs to allow for the longer encounter time required for elderly patients. In addition, support from Washington for provider training projects such as the Geriatric Center of Excellence will help to assure an adequate workforce for the care of our growing elderly population.

A major issue with providing complete primary care for the aged is the need for integration of Behavioral Health services within primary care settings. Depression and anxiety are common among elderly patients. Studies show that such emotional disorders are part of the diagnoses of up to 70 percent of persons who present with health problems at primary care centers. In West Virginia, there is great interest in models of behavioral health integration which are specific to the primary care setting. These models are being used and tested in a number of FQHCs and also in free clinics. A barrier, however, is that federal rules only allow for Medicaid and Medicare reimbursement for these services by the most highly certified behavioral health providers. In West Virginia there are not enough PhD level psychologists or Licensed Independent Social Workers interested in changing their practice to a primary care model to meet the demand of behavioral health care for the elderly in primary care settings. As many of the elderly will not go to a comprehensive community or private mental health center for care for emotional disorders, the problems often go untreated. A change in federal policy to allow for appropriately trained, masters level behavioral health providers to be reimbursed for their services in FQHCs would help to improve the overall health status of the elderly of West Virginia.